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ABSTRACT

The role of the psychologist in the implementation of the six key principles of Public Law 94-142, The Education for All Handicapped Children's Act is one of an advocate and consultant relationship to the school. A strategy for consulting with non-handicapped peers of handicapped children at the junior high school level was investigated with a semantic differential to assess attitude change. Girls showed more positive attitude changes after consultation and boys' attitudes became more negative. (Author)

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The Psychologist's Role in P.L. 94-142: Consultation Strategies with Peer Groups of Handicapped Children.

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Running Head: Strategies for Consultation

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The Psychologist's Role in P.L. 94-142: Consultation Strategies with Peer Groups of Handicapped Children.

As outlined in Dr. Silber's paper, consultation may be requested by schools at several levels - by the administrators, to plan programs and for case consultation. In working with physically and mentally handicapped children, we as pediatric psychologists, often find ourselves asking to consult with the schools. This has been particularly true in my work in a University Affiliated Facility which is an interdisciplinary training facility. We focus on assessment and treatment planning for the developmentally disabled. Historically, we have found ourselves in the role of advocate rather than consultant. We have tried to make people aware of and responsive to this population's needs. The response was most often determined by how well we pleaded or argued the child's case to the school or the community. Children were often accepted into programs as long as they were not behaviorally disruptive or if we engineered a way for the physically handicapped to negotiate the halls and steps without too much disruption to the school. Children were, in effect, having their needs met by the good grace of the school. As a professional, this meant walking a tight rope and constantly redefining goals for the child in terms of what you thought the school system would tolerate.

With the passage of Public Law 94-142, The Education for All Handicapped Children's Act, (Nov., 1975) the schools were mandated to provide a free appropriate public education to all handicapped children. This means that the schools must adapt and change to meet the handicapped child's social and academic needs rather than the child having to fit into the system or be excluded. It is the first comprehensive law for the education of the handicapped child that has "teeth" in the sense of placing contingencies on the school system to respond appropriately. For those of us who had long gone to schools on bended knees,

the passage of this law gave us and the parents a feeling of power. It strengthened our role as advocates. How should we use this power? What should our strategies be?

To answer these questions I think we must first review the six major principles of the law. They bring sharply into focus not only the schools responsibilities but what our responsibilities as psychologists are in meeting children's needs.

1) The principle of zero reject means that schools must provide free special education and related services as outlined in an Individualized Educational Program for all handicapped children between the ages of 3 and 21 years. States that do not provide education for non-handicapped children younger than 5 or older than 18 are not required to provide for handicapped in the same age range. Equal opportunities must be provided in academic programs as well as extra-curricular services including counseling sessions, athletics, transportation, health services, recreation and special interest groups and clubs, and employment and physical education services (Turnbull & Turnbull, 1978).

This means that as advocates we must be cognizant of more than the child's cognitive skills. We must learn more about what is "appropriate" in the areas of recreation, physical education, special interest groups, etc. if we are to assure that the child's needs are being "appropriately" met. We must not allow past expectations in these areas to influence our goals. Most important we will have to look to the child, himself, for guidance. Not all children want to join clubs or take part in certain recreational activities, and we must avoid advocating a position that opposes the child's needs and desires.

2) The principle of non-discriminatory evaluation requires selectivity in the procedures we use with an individual child rather than "basic tests administered to or procedures used with all children in a school, grade or class."

(Federal Register, August 23, 1977, p. 42494). A multidisciplinary team approach is mandated that assesses specific areas of educational needs and all areas related to the suspected disability including, where appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status and motor abilities. (Federal Register, August 23, 1977, p. 42496-42497).

What does this mean for us as psychologists who work with these children? It means we must go beyond the usual battery of tests that compare a handicapped child to the normal population. It means we must recognize the limitations of our evaluation skills and learn to effectively use and understand other disciplines such as Communicative Disorders, Physical Therapy and Occupational Therapy. Since we are to use assessment for the purpose of planning appropriate programs, a functional behavior analysis will be critical. Part of any evaluation will now have to include observing the child in the school environment in which he will be expected to function. The environment can set the stage for behaviors to increase or decrease and only by observing the child in the environment can one adequately plan effective intervention programs. Indeed, if we are to be effective advocates, we must expand our traditional evaluation skills.

3) Individualized Education Programs (IEP) must be written for each handicapped child to meet his or her specific needs in the areas of academics, social adjustment, adaptive behavior, physical education and vocational development. The school or parents may request the presence of a psychologist and this assures our input into the intervention plans and programs. Individual programs must be outlined including specifics of what is to be taught, how it will be taught and how progress will be measured.

This certainly clarifies that evaluation reports must produce more than general statements such as "He needs training in the perceptual-motor area".

Psychologists, unfortunately, have not always been known for outlining specific intervention plans as part of their evaluation report. We will certainly have to have more input from educators and other specialists as well as look more carefully to our own body of research if we are to aid in developing effective programs. Ensuring that there is an appropriate evaluation of progress component in the educational programs will be important. Too often we have had to accept "He's doing fine", "It's working well" as the last word in assessing a child's progress. Sharing data collection systems and evaluative approaches will be important. While we have previously chastised school systems for not having better evaluation systems, we will now have to try to help them in this difficult process. The IEP also gives us the opportunity to research systematically the effect of different approaches.

4) Placement of children in the least restrictive environment is another key principle in Public Law 94-142 that will require careful consideration on our part. Least restrictive means that handicapped children should be educated with non-handicapped children to the maximum extent appropriate. Efforts must be made to ensure that no harmful effects occur to the handicapped child as a result of this placement. Cruickshank (1977) states some concern with the concept of "least restrictive environment". "The plan will not, in and of itself, solve a single problem of a single child. Already a ground swell of new frustrations is observable within regular class teachers' groups and from parents who realize that the "least" may indeed be the "most" restrictive, perhaps to an even greater extent than poor quality special educational programs." (p. 193).

This is a double-edged sword for those of us who are aware of the effects of teasing, belittling and ignoring on handicapped children's emotional development. The regular school environment often accentuates the child's weaknesses. On the other hand, handicapped adults in a study by Turnbull, Raper, and Mesibov (1977, in press), indicated that they felt placement in a regular class would be better for social and emotional development as compared to special classes.

They also clearly stated that being with "normal" peers was not enough. They indicated the need for support from interested teachers and counselors, methods to cope with the risks involved in the regular environment and the need for their "normal" peers to be educated about handicapping conditions and the people who have these handicaps.

The mandate for us as psychologists is clear in this area. We must move beyond considering the emotional atmosphere in the home to include the school environment. We must listen more closely to the teacher's needs and evaluate her support system. Most teachers are not trained to educate academically the blind, the cerebral palsied, the child dying of leukemia, the mentally handicapped child, let along help them with their emotional and social development. For example, the need to inform and educate became apparent when we visited a local school system to discuss placement options for a 6 year old severely involved Cerebral Palsy child. She was non-ambulatory, had no expressive language but was reading at the 1st grade level. She had been in the Gifted-Handicapped Preschool in our facility. After listening to our description of the child's strengths, weaknesses and special needs, the Special Education Coordinator said, "She'll have to go into the class with the severely and profoundly retarded." After gasping in disbelief, we managed to as, "Why?". She replied, "She can't walk, she can't talk and she's not toilet trained, therefore, she's severely retarded." Informing administrators about various strengths and weaknesses is not enough. We must share our special knowledge that often seems common knowledge because we know it. Administrators don't usually have the training to know that CP children can be severely retarded physically but not mentally, they are not aware of the emotional needs of the burned child who wears a Job's mask and they don't necessarily know how to dead with a trainable mentally retarded child who is entering puberty. Sharing basic information about the handicapping condition with peers as well as the handicapped child will also be important. This certainly adds a new dimension to our consultation role that goes beyond school administrators and teachers and back to the child himself and the peers he must interact with on a daily basis.

5) The Principle of Due Process ensures fairness of educational decisions and accountability of both professionals and parents in making decisions. It involves an impartial hearing conducted by an officer not associated with the school.

It is often at this point that the parents or school might ask for expertise outside the school agency and it is in this process that we, as psychologists, will very often be involved. To do this, we must not only have a thorough knowledge of the law but also skills and strategies to evaluate the situation in a way that facilitates the school and parents working together. The child is often forgotten in the midst of a battle to have his needs met. In the past we have had to be advocates for parents but this role must be tempered by professional objectivity.

6) Parental Participation is listed as a separate principle in Public Law 94-142 to ensure parents "access to records and information and in the development of educational policy." (Turnbull & Turnbull, 1978, p. 16). The law provides for parent participation in all aspects of the child's educational process.

Parents will need support and education for their roles in the school setting if their partnership with the school is to have any real meaning. Simply including them in a program planning meeting will not be sufficient nor should they rely totally on outside professional agencies to speak for them. We will need to share our information more clearly to them, help them to ask questions, state their opinions and goals, and set up mechanisms for them to have ongoing discussions with the school. We, in effect, will have to model greater parent participation in our interactions with our clients' parents if we are to encourage it at the public school level.

This brief review of the 6 key principles outlined in Public Law 94-142 points out some areas in which we must grow professionally and the need for us to be consultants as well as advocates.

An advocacy role can be defined as one that pleads or defends the cause of another. A consultation role is one which involves a helping process between the consultee who is trying to solve a problem or develop a plan and a consultant who is trying to help in these efforts. We must, as Advocates, always keep in mind the needs of our clients and their right to have these needs met and, as Consultants, we must help the school fulfill the intent and spirit of Public Law 94-142 in giving appropriate education to all handicapped children. Who are our consultees? Our consultees are the administrators, the teachers, the parents, the child, the child's peers and their families. Our role has been strengthened and our responsibilities increased. We are no longer going to schools on "bended knees" yet we go to perform a task that will be demanding. What strategies should we use to manage this consultation task?

Consultation can occur on essentially three levels:

1) Information or Task Oriented Consultation
2) Training Consultation
3) Ongoing Collaborative Consultation

When asked to consult, the consultee, whether it be the school or parent, might be asking you to provide expert knowledge in one area and not to take any further part in a problem-solving process. In this role you would be simply a provider of particular information or a specific service. You could also be asked at another level to provide training so that people in the system have the skills to solve the problem themselves. Dr. Adams in his paper will discuss an example of this type of consultation. Ongoing Collaborative Consultation involves a system needing to adapt and respond to a situation that changes over time. This model focuses on the collaboration of consultant and consultee over a long period of time. It could at various points involve both Information Sharing and Training. I would suggest that it is at this level of consultation that we must approach the task of helping to educate our handicapped children. It is an ever "developing" process. A systematic approach at this level of

consultation is needed and should include defining problems, goals, developing alternative solutions, providing training for needed skills, implementing the solution and evaluating the effect of the solution.

Consultation Strategies with Peers

I would now like to present the approaches that we used to consult with a 13 year old mildly retarded client and his peer group.

John had been mainstreamed into a regular 7th grade class upon return from a residential setting. To help him adjust to the school situation we established a group with 4 peers that met once a week. The children had all volunteered with their parents' permission to talk with John about appropriate behavior in the cafeteria, the halls, during break time and before school. The children also acted as resources to John when he found himself "not knowing what to do." This, in effect, provided a positive peer group for John. Other children in the school did not, however, model this particular groups' understanding and helpfulness. Teasing was always at a high level and John was actually encouraged to engage in inappropriate behavior. For example, one day a group of children urged John to eat 10 full trays of food in the cafeteria. John's explanation for his behavior was "I wanted them to like me." Such interactions between John and his peers made it clear that our consultation strategies needed to be modified. What strategies could we use to facilitate more appropriate interactions between John and his peers. Perhaps we needed to teach peers more appropriate interaction skills. Perhaps the attitude of the administration and teachers was a poor model for John's peers and needed to be modified. While work at the administrative and teacher level had been done, it was apparently not enough. We listened more closely to the teachers' concerns and also began sending periodic memos about John's progress and needs. We talked to classes that were having a

particularly hard time accepting him. We also talked with John about his responsibilities, role played with him and set up a token system to increase appropriate behavior. All of these things helped to some extent but we realized we had still not done a good job of consulting with the peer group. We were obviously in the role of advocates and not consultants. The peers did not seem to see this as their problem but rather our problem and John's problem.

Work by Peiper (1974) suggests ways to alter non-handicapped children's misperceptions of physically handicapped peers, and to make them aware of what handicapped children can do. She suggests discussions about causes, experimentation with orthopaedic appliances, handicapped visitors to the classroom and the use of specially designed books, records, and films to accomplish those objectives. A similar program was developed by the Meeting Street School (1976) in cooperation with the Rhode Island School System to prepare teachers and students in grades 1 - 4 for students with handicapping conditions. Westervelt and Turnbull (1978) indicate that to facilitate handicapped and non-handicapped children's social interactions the non-handicapped child should be able to "understand the realistic constraints of a peer's handicapping condition and, more importantly, be aware of the similarities between himself and his handicapped peer such that he sees himself more alike than different" (p. 12-13). They suggest increased exposure of non-handicapped to handicapped children, opportunities for discussions, role playing and films that incorporate the "similarity" theme. Films (Brightman, 1978; Bookbinder, 1976) and T.V. programs such as Sesame Street (Corn, Goldberg and Kanungo, 1976) have been used to increase this positive "more similar than different" attitude. The empirical evidence for or against all of these suggested methods is limited and will need careful documentation if consultation strategies in this area are to improve.

With John's school, we had the opportunity to use a Film-Discussion Format when a 9th grade class invited me to talk with them about the handicapped. I chose the topic "What It Means to be Different" with emphasis on the peers feelings

and their perception of handicaps rather than on a particular handicapped person's needs. I started by describing "difference" on a continuum and stated that in many ways we are all "different" and similar to each other. I encouraged them to put labels on their reactions and feelings to people they saw as different. To do this I had them close their eyes as I presented graphic scenes of a very fat person getting on a bus, a woman without arms in a grocery store picking up a pear with her feet, a man with a big head walking down the street, and finally, the word "retarded". After each scene they were to shout out their first reactions. Their responses which I wrote on the board included words such as "crazy", "disgusting", "sick", "dumb", "scared", "sorry", "weird", "grass" and the name "John" was a common response to the word "retarded".

The movie "A Day in the Life of Bonnie Consolo" was then shown. Bonnie Consolo is a woman born without arms and she takes you into her life as a mother, a wife and woman with a handicap. She beautifully describes her feelings, the communities' reaction to her and the film clearly demonstrates her similarities as well as differences.

After the film, the students were asked to label their reactions to Bonnie. The words included: "interesting", "amazing", "fantastic", "not different", "wonderful", "normal". A discussion then followed on how we get from the negative reactions to the positive ones. A major emphasis was placed on the fear of the unknown and the unexpected and that once we know what to expect we are in a better position to appreciate a person's strengths as well as their weaknesses. The value of "being different" in terms of uniqueness and making life interesting was discussed. The handicapped or "different" person's needs to be accepted, to be loved, to feel successful and to feel self-worth were pointed out in relationship to the film.

Finally, we brainstormed on what they could do to understand and appreciate the handicapped. Simple things like making eye contact and smiling were

mentioned as well as many personal stories on how they got to know and appreciate someone who was different. The response to this presentation as indicated by the discussion and comments given later by the children was very positive.

I was later asked by 3 other classes to do the session for them. Vic Dmitruk and I took this opportunity to systematically look at the effect this type of presentation had on the children's attitudes. A semantic differential consisting of 12 adjectives each rated on a 7-point scale (Osgood, 1962) was used to assess the children's attitudes before and after the presentations. The adjectives used for people were healthy, sick, retarded, blind, deaf, fat, smart, strong, old, ugly, crippled and people with broken arms. Ten dimensions were rated: beautiful-ugly, fresh-rotten, alive-dead, warm-cold, nice-awful, sweet-sour, clean-dirty, clear-cloudy, good-bad, and day-night.

Seventy children, 36 boys and 34 girls, participated in the sessions. The classes were split with half of the children doing a pre-test (19 boys and 16 girls) and the other half a post-test (17 boys and 18 girls).

A 2-way analysis of variance was done comparing attitude change on the pre-post test scores and sex for each adjective. The possible range of scores was 7 to 70 with the mean scores falling between 25 to 50. Overall, none of the post-test scores were significantly more positive than the pre-test scores except for the adjective "strong people" ($p < .025$). An inspection of the data showed that the session affected the boys differently than the girls with the girls becoming more positive and the boys becoming more negative.

There were several significant changes in pre-post test scores as a function of sex.

Insert Table 1 About Here

Girls were changed to a more positive attitude than boys on the adjectives retarded, deaf, fat, old and ugly people. The boys were affected more negatively than girls on all but the adjectives smart and strong.

It is important to note that the significant sex differences occurred on the adjectives that were relevant to the film and images given at the beginning of the session. Those adjectives showing sex differences were crippled, retarded, ugly, old, blind, deaf and fat and no differences were shown for adjectives such as healthy, sick or broken bones. These changes in attitude scores are, therefore, not likely to be a placebo effect of simply showing a film and talking to the group, but rather a result of the session's topic.

A possible explanation of the sex differences is that the star of the film was a woman who did have the extreme physical abnormality of missing both arms. Richards (1970) has shown that from kindergarten to high school, children's attitudes change to resemble those of the same sexed parent. Girls were found to rate cosmetic handicaps lower than boys and boys rated functional handicaps lower than girls. The boys in our study did show a more negative post-test score on the adjective - "crippled people" indicating that the session actually enhanced their negative feelings. On the other hand, the picture of a startlingly handicapped woman making it in the world seemed to positively affect the girls' attitudes, especially on cosmetic adjectives such as ugly and fat.

The need to evaluate systematically the effect of consultation strategies with children is pointed out in this study. The sex and age of the child appears to have strong implications for the strategy you use. The fact that the strategy described here had a negative effect on junior high school boys' attitudes is certainly food for thought.

Footnotes

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Table 1

Mean Attitude Shift Scores in the Semantic Differential as a Function of Sex

	Pre-Post Gain Scores		
Semantic Differential	Girls	Boys	F Ratios
Retarded People	4.85	-5.4	F=10.02 P<.003
Fat People	4.7	-3.5	F= 8.16 P<.058
Old People	5.5	-1.3	F= 6.92 P<.010
Ugly People	8.4	0.8	F= 6.76 P<.011
Crippled People	1.7	-6.4	F= 4.59 P<.056
Deaf People	4.9	1.3	F= 3.81 P<.055
Blind People	-0.2	-1.6	F= 3.48 P<.066
Sick People	-4.6	-0.6	F= 1.91 N.S.
Smart People	-0.7	3.4	F= 1.83 N.S.
People with Broken Bones	6.5	-2.7	F= 1.46 N.S.
Strong People	2.1	4.4	F= 0.24 N.S.
Healthy People	+3.5	-3.3	F<1 N.S.

P.L. 94-142

Six Key Principles

I. Principle of Zero Reject

II. Principle of Non-Discriminatory Evaluation

III. Individualized Education Programs (IEP)

IV. Least Restrictive Environment

V. Due Process

VI. Parental Participation

Levels of Consultation

1) Information or Task Oriented Consultation

2) Training Consultation

3) Ongoing Collaborative Consultation